

True Cost of Denials

Strategies to Increase Revenue Cycle Efficiency

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Mega Healthcare Conference



Introduction



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Discussion Topics

What are Denials Costing your Organization?

How to Design Meaningful Denial Reports

Improving First Pass Payment Rate

Preventing our Most Common Denials

Who Really Bills Claims?

Green

Patient Access

Blue

HIM/Coding

Orange

Charge Master

Yellow

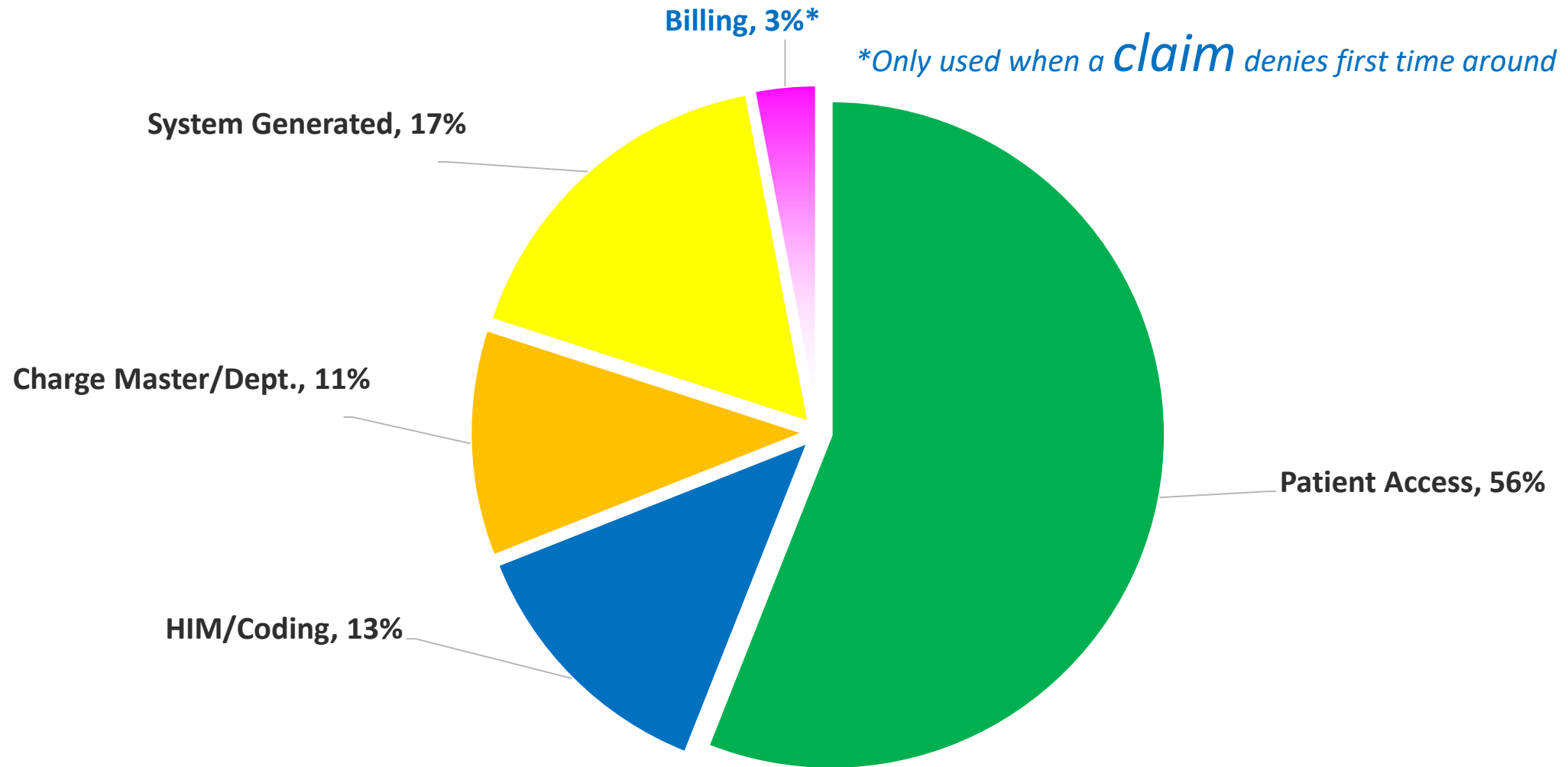
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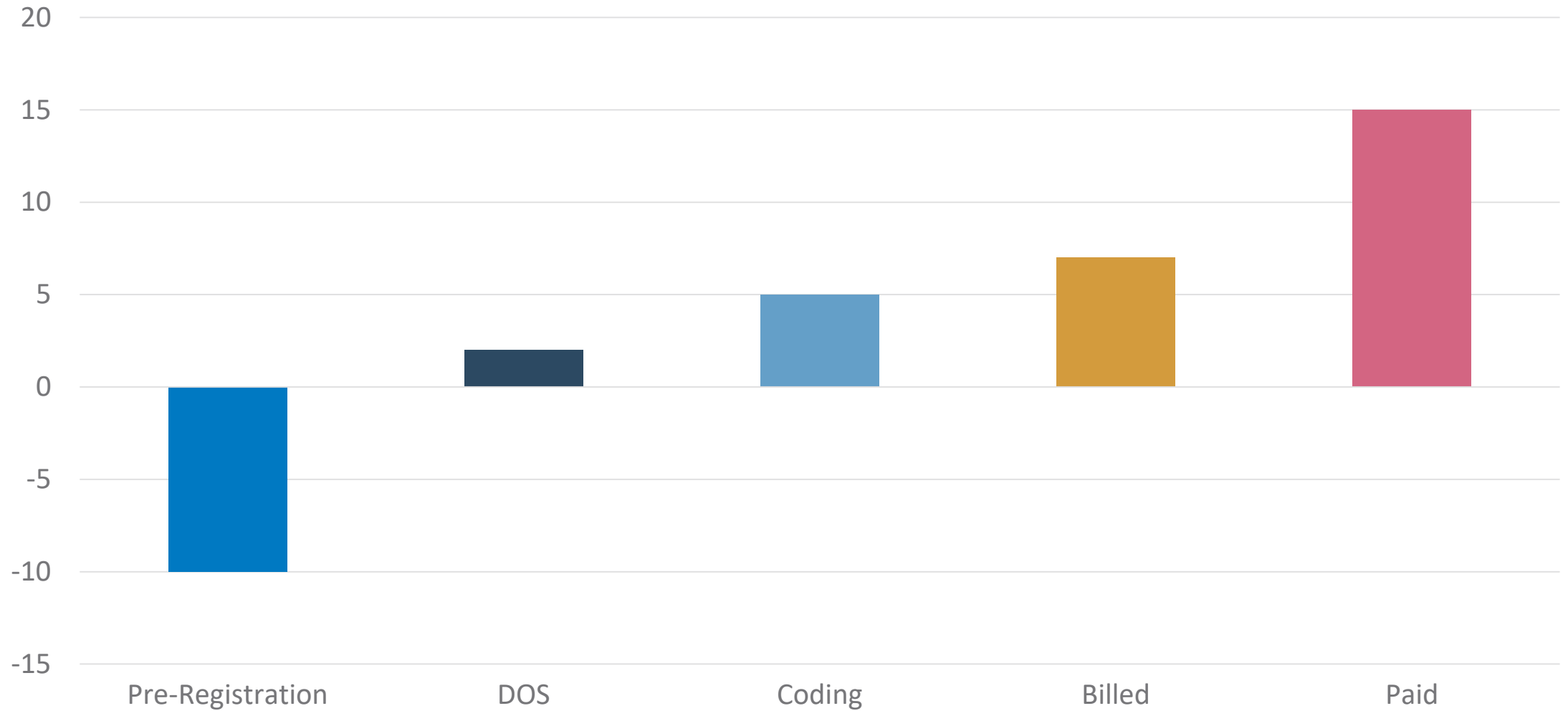
Billing

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5a MED REG #		5b FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE				11 SEX		12 DATE	
13 HR		14 TYPE		15 SRC		16 DNR	
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Not the Billing Department



Timeline of a Paid Claim



Payment Turnaround Times

Statement Date To Import

	Current Month	Last 6 Months	Community
Institutional	13.6	13.1	16.2
Professional	12.6	12.4	14.2

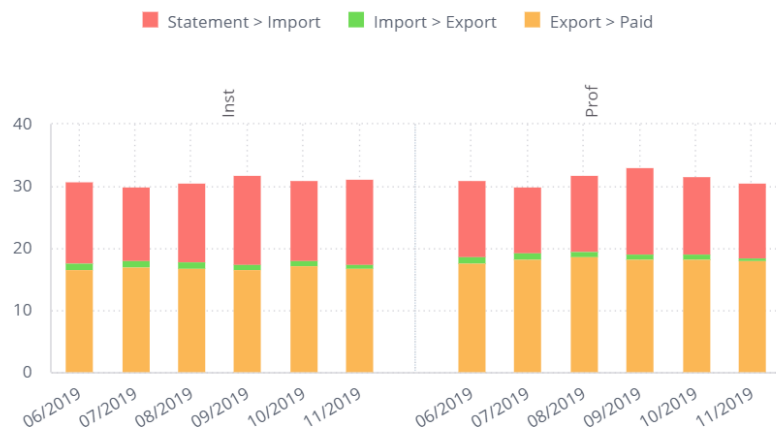
Export To Paid

	Current Month	Last 6 Months	Community
Institutional	16.8	16.9	17.8
Professional	18.2	18.3	16.8

Payer Turnaround (3 Months Avg)

Parent Payer	Turnaround
AETNA	32.1
DEAN HEALTH PLAN	28.6
DEAN MEDICAID	27.8
AARP	26.5
ALLIANCE	24.2
GROUP HEALTH OF SC WI	22.7
MED ADV SECURITY HEALTH	18.5
MED ADV UHC PAYERS	18.1
MED ADV UHC	17.6

Claim Turnaround Trend



Provider Turnaround (3 Months Avg)

Provider NPI	Turnaround
1740425057	18.9
1336488741	14.4
1861466153	14.1
1225003445	13.4
1396884474	13.2
1134194004	12.4
1205975380	11.5
1972942019	11.3
1609841568	10.6

Contract

Provider NPI

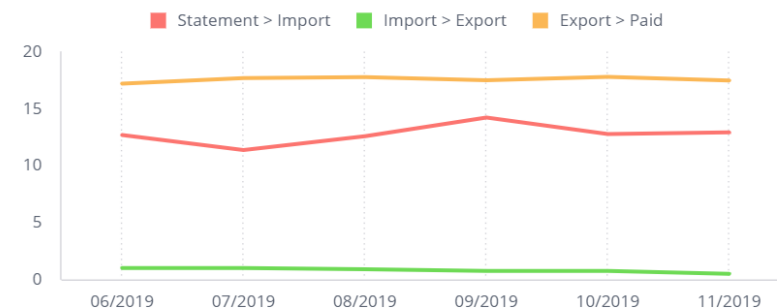
Month

SAUK PRAIRIE MEMORI...

All Providers

[-001] 2019 - December

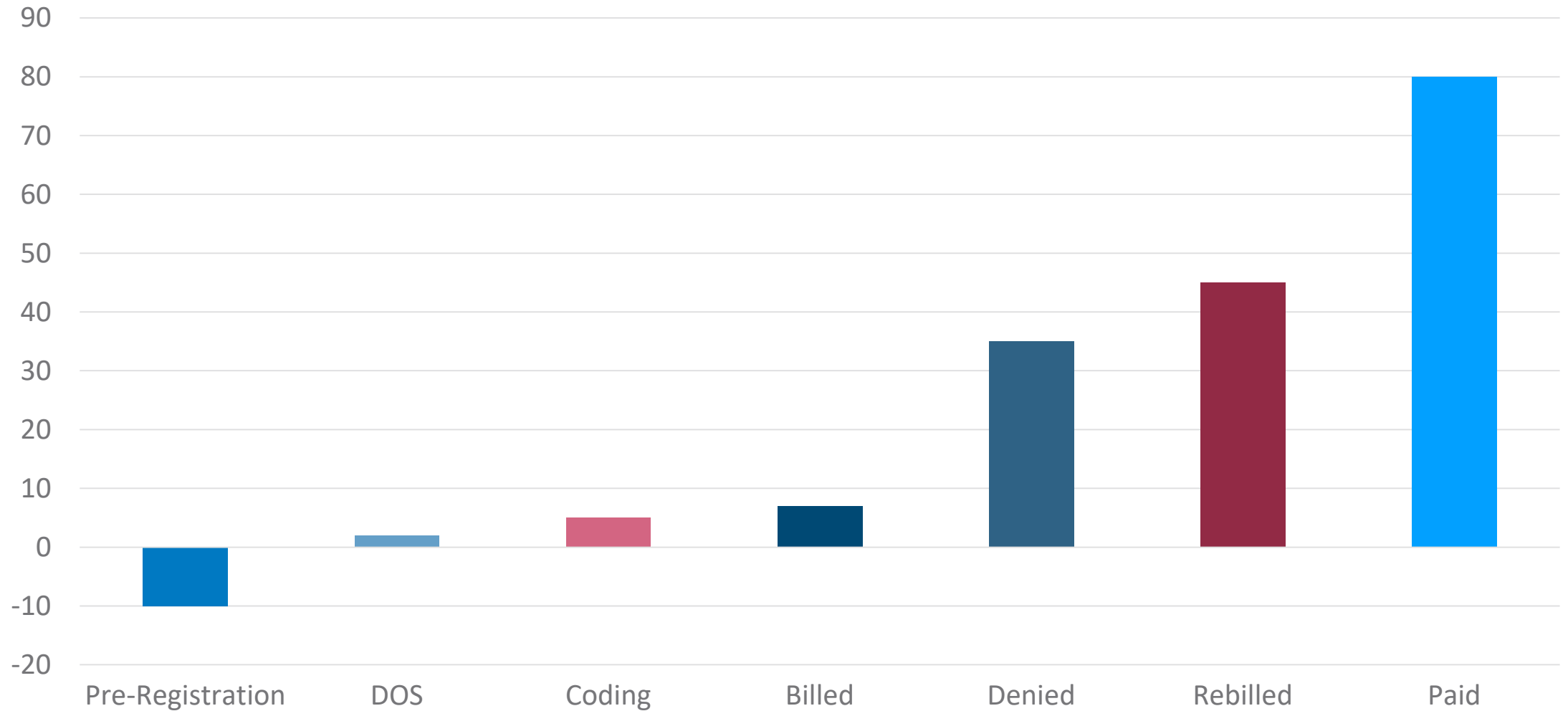
Bill Cycle Trend



Type of Bill Turnaround (3 Months Avg)

Claim Type TOB	Turnaround
81	23.2
111	17.4
21	15.7
132	15.5
141	14.6
131	13.8
22	13.2
23	12.8
11	12.1

Timeline of a Denied Claim



Payment Turnaround Time

If you bill correctly, they will pay

If you bill correctly, they will pay
most claims in 15 days

If you bill most of your claims correctly and
keep your
unbilled < 7 days, **GDRO in the 30s is easy!**

Cost of Unnecessary Denials

Cost to rework a claim due to denial = \$118

- Denial rates average 10-40% of claims
- Almost 60% of claims rebilled after a denial – DENY AGAIN!

10,000 claims x 20% FPDR = 2,000 denials

2,000 x \$118 per denial = \$236,000 per month

1,500 denials worked per FTE per month

Calculating Denial Rates

- How are you reporting denial statistics?

Denials resulting in write-offs

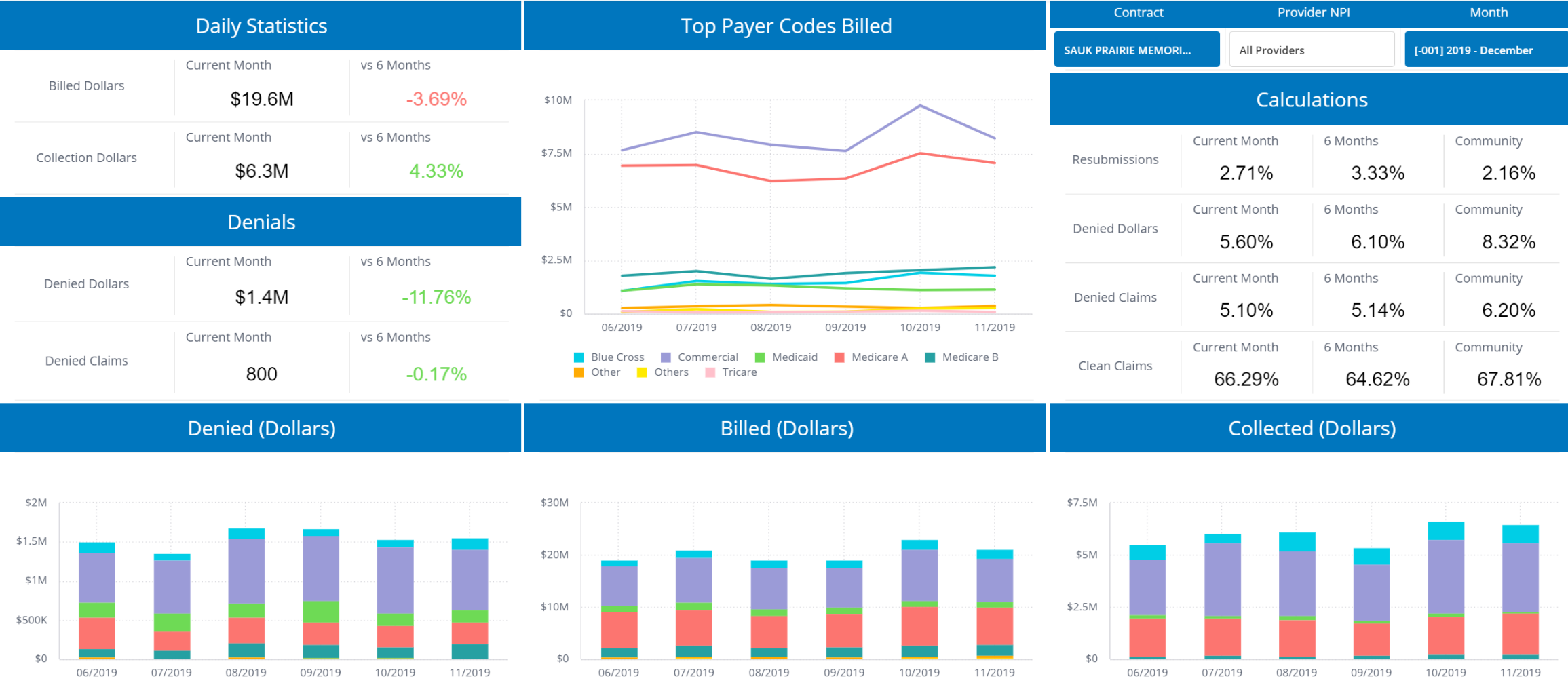
Service line versus total claim denial amounts

Charges denied as a percent of revenue

Volume of denials being reworked by staff

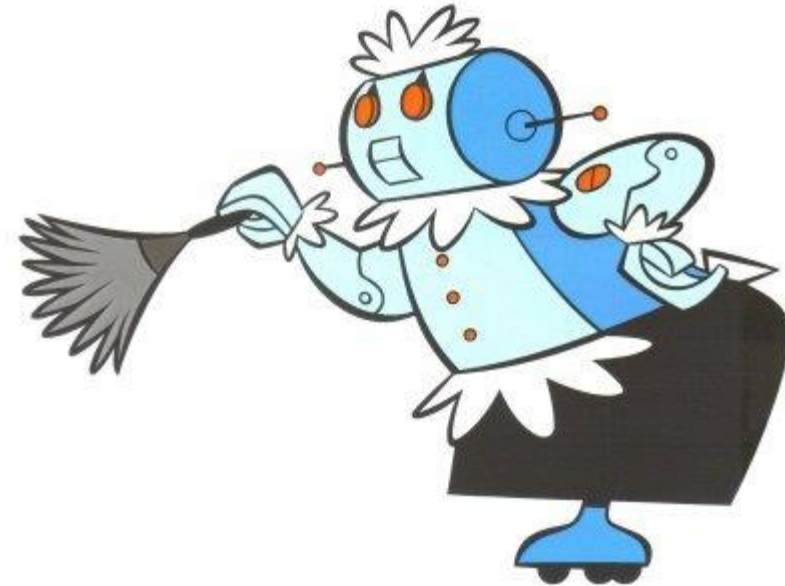
Anything not paid on first submission

Sample Performance Dashboard

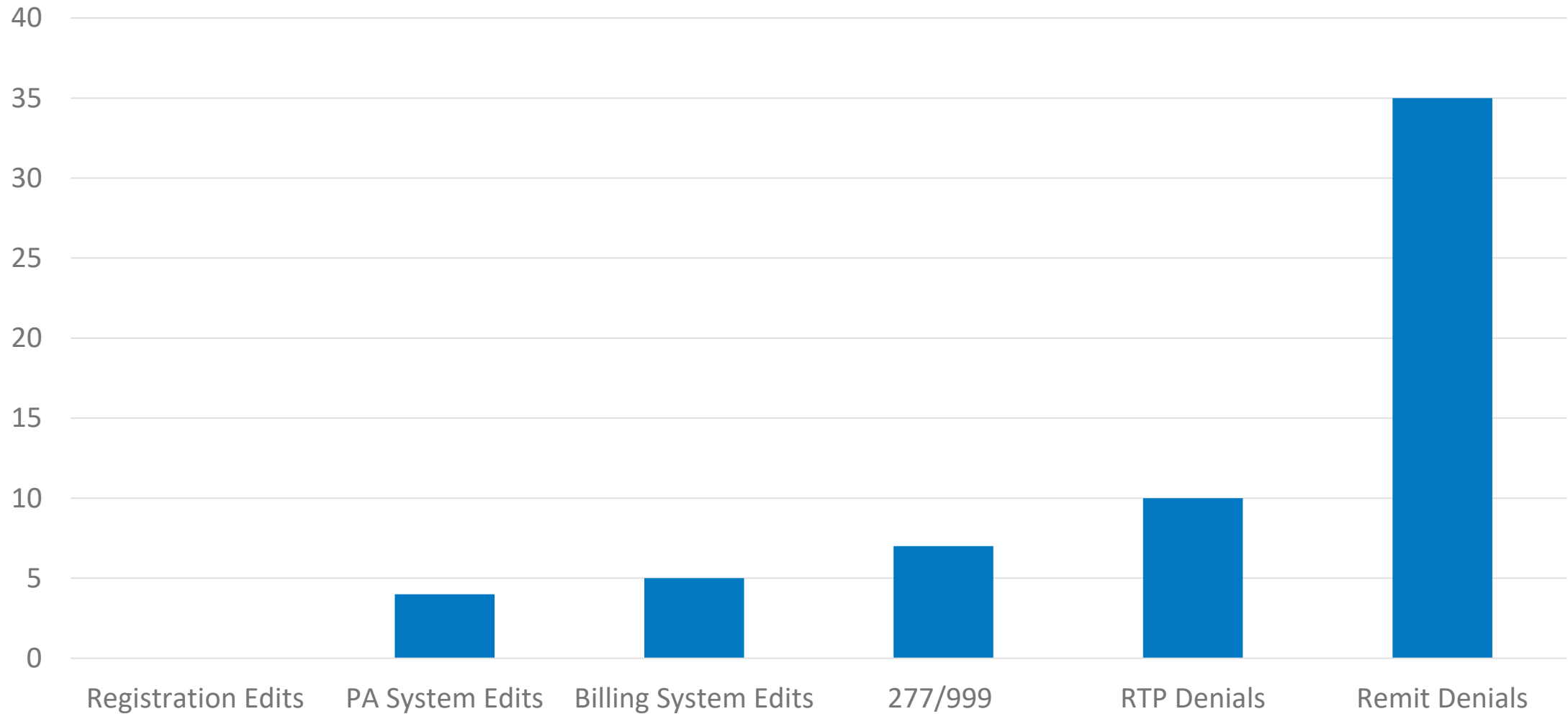


Clean Claim Rate

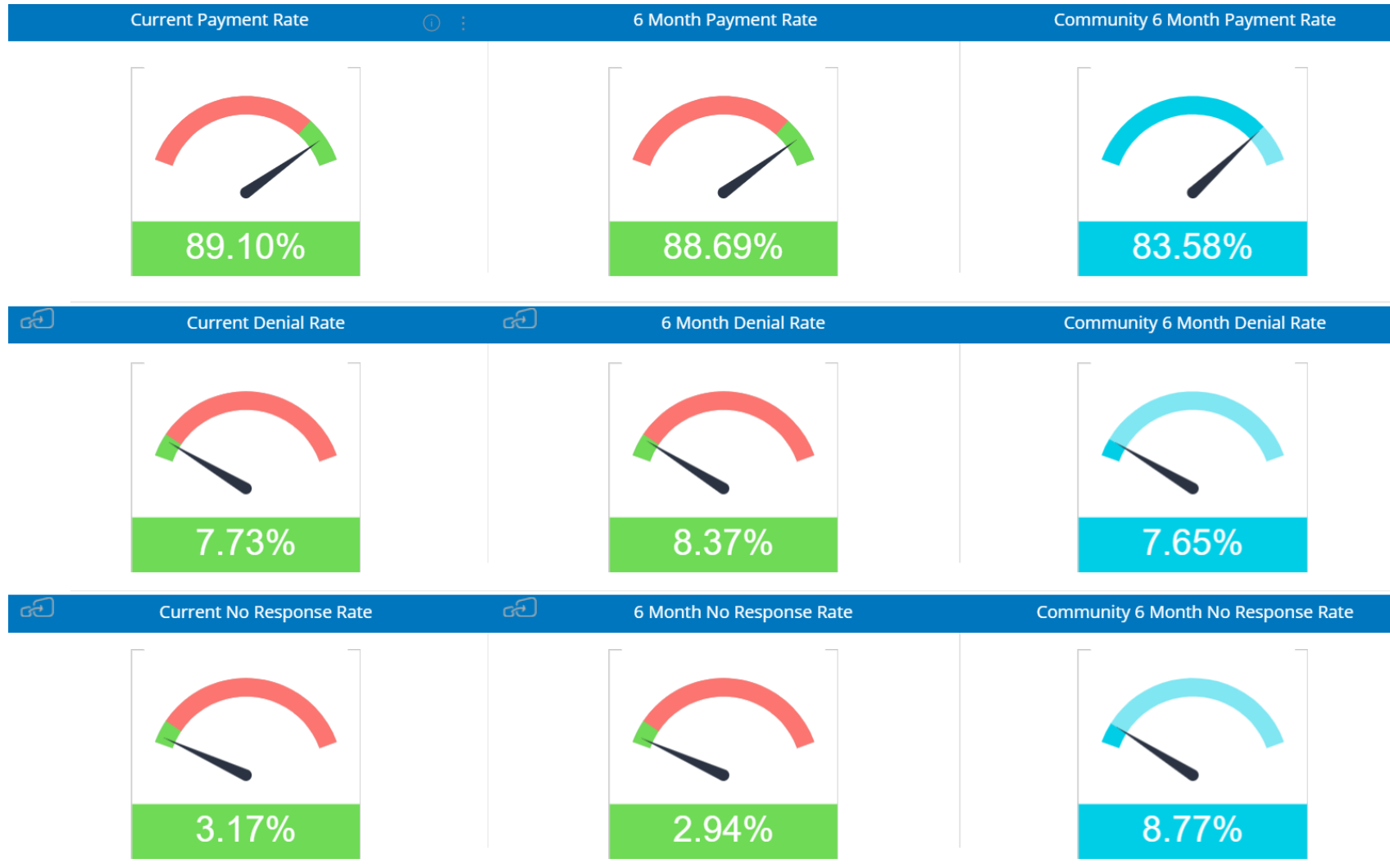
Contract	Provider NPI		Month
SAUK PRAIRIE MEMORI...	All Providers		[-001] 2019 - December
Calculations			
Resubmissions	Current Month	6 Months	Community
	2.71%	3.33%	2.16%
Denied Dollars	Current Month	6 Months	Community
	5.60%	6.10%	8.32%
Denied Claims	Current Month	6 Months	Community
	5.10%	5.14%	6.20%
Clean Claims	Current Month	6 Months	Community
	66.29%	64.62%	67.81%



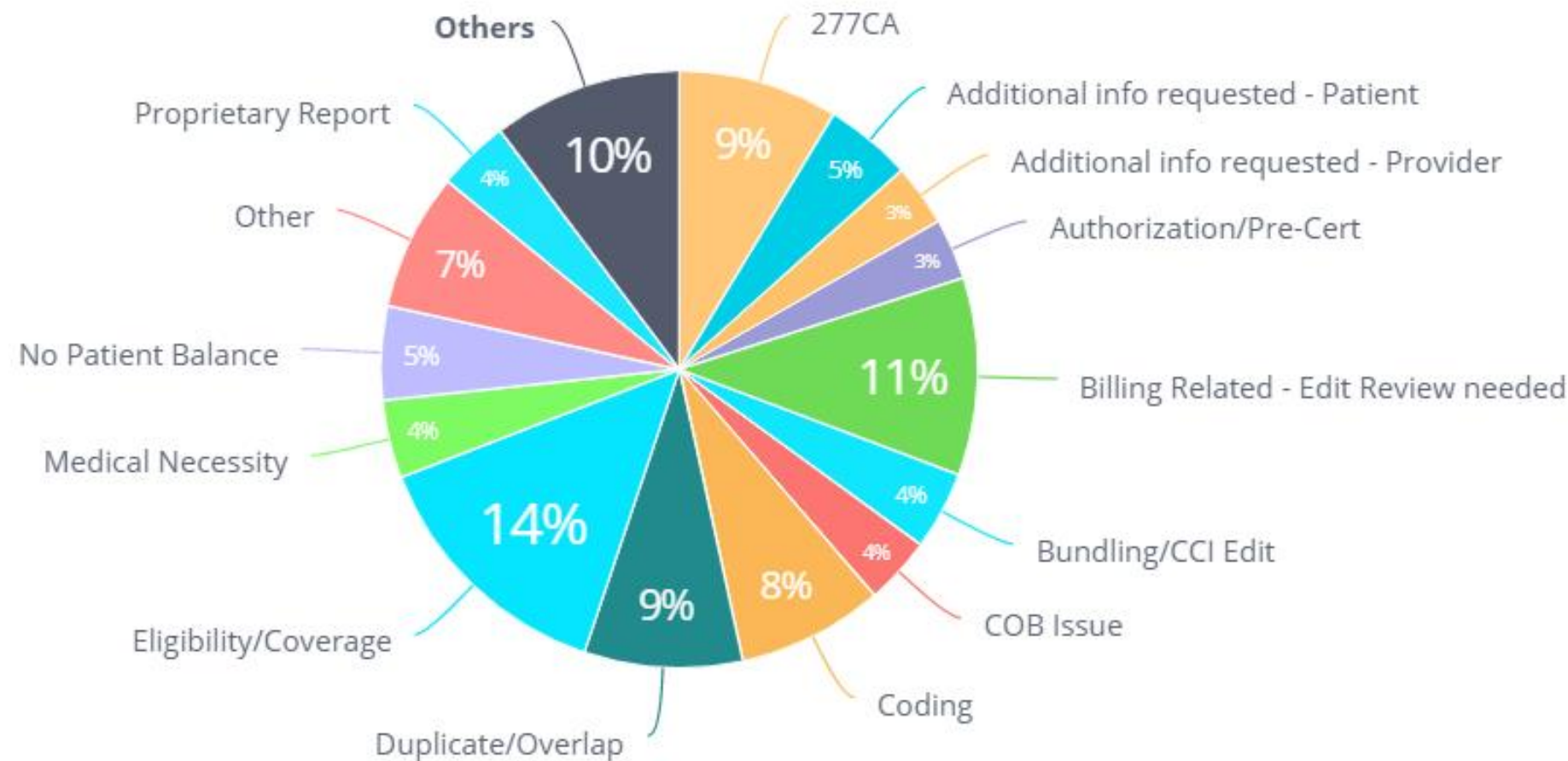
Timeline of Critical Denial/Edit Points



First Pass Payment Rates



Sample Denial Report



Denials by Category

Denial Category	# of Claims	Total \$ Denied	% of Claims	% of Dollars
Additional info requested - Patient	132	\$ 131,942.51	3.6%	4.2%
Additional info requested - Provider	204	\$ 621,305.48	5.6%	20.0%
Authorization/Pre-Cert	106	\$ 101,816.42	2.9%	3.3%
Benefits Exhausted	42	\$ 33,012.81	1.2%	1.1%
Billing Related - Edit Review needed	785	\$ 308,042.52	21.6%	9.9%
Bundling/CCI Edit	98	\$ 14,184.00	2.7%	0.5%
COB Issue	284	\$ 109,451.93	7.8%	3.5%
Coding	112	\$ 55,211.77	3.1%	1.8%
Duplicate/Overlap	461	\$ 854,248.06	12.7%	27.5%
Eligibility/Coverage	756	\$ 297,024.26	20.8%	9.6%
Exceeds Frequency	51	\$ 45,073.67	1.4%	1.5%
Medical Necessity	72	\$ 211,779.28	2.0%	6.8%
Other	191	\$ 109,688.08	5.3%	3.5%
Other Facility Overlap	37	\$ 5,638.18	1.0%	0.2%
Provider Enrollment	41	\$ 11,518.50	1.1%	0.4%
Timely Filing	264	\$ 197,471.87	7.3%	6.4%
Grand Total	3636	\$ 3,107,409.34		

Putting Data to Work

- Where do I start?
- What are the easy fixes?
- What can be fixed in our EMR versus the Clearinghouse?
- Set goals each week to meet a reduction in denials.
- Accountability from start to finish.



Denial Management

Track all denials by payer



Use system reports – Zero pay posting with ANSI reason and remark codes



Select highest volume and highest dollar denial reasons each month to focus on reducing or eliminating



Add required registration fields, coding, prior authorization and billing edits or system holds to prevent claims from billing with incorrect data

Going Beyond the Data

- Committee to discuss denials as well as patient concerns.
 - Chiefs, Directors, and Super Users
- Sub-committees to focus on specific denials
 - Ex: No ABN's, Surgery Codes, Eligibility
- Education to registration staff and providers as needed.
 - Eligibility Verification day of the visit
 - Attend Med Staff meetings



Workers Compensation

W/C Denials – Records Requests

- 100% verification and send records with initial claim.
- If verification is missed, edits hold claim and biller verifies before releasing with records.
- If unable to verify with W/C, bill patient or bill health insurance.

No Authorization Denials

Communicate authorization requirements with staff responsible for obtaining it

Make sure contracts are clear on what requires authorization

Design edits to look for payers/services that require authorization

Stop claims with no authorization before billing

Questions



Thanks for joining us!

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